

Fishermen's Fund

FISHERMAN'S REPORT OF INJURY/ILLNESS & CLAIM FORM

You must file within one year of first treatment. Complete each item below – benefits cannot be paid if you do not provide the requested information. Attach a copy of your license/permit card with this form.

1. Name (Last, First, Middle Initial)		2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth	4. Social Security Number
5. Street or PO Box Number		6. Home Telephone Number () ()		7. Cell Phone Number () ()
8. City	State	Zip Code	9. Email Address optional	
10. Vessel Name	11. Owner of Vessel/Set Net Site	12. Vessel Owner's Phone Number	13. Vessel Number	
14. Commercial Fishing License or Permit Number _____ Date Purchased _____ Must Attach Copy		15. Date and Time of Injury or Onset of Illness Date: _____ Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm		
16. Geographic Location at time of injury (chart name or description, nearest landmark, etc) Be Specific		17. Ill/Injured while <input type="checkbox"/> Commercial Fishing <input type="checkbox"/> Working on gear/boat <input type="checkbox"/> Other: _____		
18. Resource Commercially Fished (ex. Salmon, Cod, Crab, etc)		19. Gear Type (ex. Troll, Seine, Longline, Pot Gear, etc.)		
20. Is the vessel/site insured by a protection & indemnity (P&I) insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes, Insurance Company Name: _____ Have you filed a claim against the vessel owner or the insurance company <input type="checkbox"/> Yes <input type="checkbox"/> No				
21. At the time of your injury/illness, did you have medical coverage (including private health insurance, Indian health services, veterans affairs, Medicare, Medicaid, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of coverage provider _____				
22. What is the exact nature of your injury/illness? Be Specific				
23. What caused the injury/illness? Be Specific				
24. What were you doing at the time of injury? Be Specific				
25. Was there a witness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, witness name: _____ witness address: _____ telephone number: _____				
<p>To all health care providers: You are authorized to provide the Alaska Commercial Fishermen's Fund information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above in box 21. This information will be used to evaluate my entitlement to receive medical benefits from the Fund.</p> <p>Claimant Signature _____ Date _____</p>				

Warning: It is a crime to provide false information for the purpose of defrauding the Alaska Commercial Fishermen's Fund, or any other person. Penalties include fines and/or imprisonment. In addition, the Fund may deny all benefits if false information materially related to this claim was provided by the claimant.